1973 REPORT

LEGISLATIVE RESEARCH COMMISSION

A STUDY OF THE "GEOGRAPHIC UNIT" CONCEPT WITHIN NORTH CAROLINA STATE MENTAL HOSPITALS

CONTENTS

INTRODUCTION

On May 14, 1971, the North Carolina General Assembly ratified House Joint Resolution 715 as Resolution 66 of the 1971 Session. This Resolution directed the Legislative Research Commission to "study the 'geographical unit' concept within the state mental hospitals to evaluate the practicality, the effectiveness and the economy of this type of operation." (A copy of HJR 715 is contained in Appendix I.)

Pursuant to the direction of HJR 715 the Co-Chairmen of the Legislative Research Commission appointed Representative Carl J. Stewart Chairman of a Committee which was to undertake the study and to report its findings back to the full Commission. Representative Stewart is a member of the Legislative Research Commission; other members of the Committee on the Geographic Unit within State Mental Hospitals were drawn from the General Assembly at large. The Committee members are: Representative Robert Q. Beard, Representative James T. Beatty, Senator Luther J. Britt, Jr., Representative Nancy B. Chase, Senator David T. Flaherty, and Representative Joseph B. Raynor, Jr.

The Committee had a number of meetings and public hearings, made individual visits to state mental institutions, and received for its consideration a summary of a recent State Bureau of Investigation report on North Carolina mental hospitals. Dr. Eugene A. Hargrove, Commissioner of the N. C. Department of Mental Health, and Dr. Eugene Malony, a practicing psychiatrist

with experience in the State Hospital system, participated in Committee meetings. Staff assistance was provided by Mr. David Warren, Assistant Director of the Institute of Government, and Mr. William H. Potter, Jr., Research Director for the Legislative Services Office.

BACKGROUND

The Committee initially found the directive of HJR 715 ambiguous. The resolution was captioned "A Joint Resolution Authorizing and Directing the Legislative Research Commission to Study the Area Unit Concept of Treatment of the Mentally Ill ..." (emphasis added) yet the commissioning Section 1 of the resolution limits the scope of the directive to an evaluation of the geographic unit concept.

THE AREA PROGRAM

The confusion in the resolution is easily understood. The Area Program is a concept clearly articulated in G.S. 122-35.18 through G.S. 122-35.22. These sections of the General Statutes, Article 2C. Establishment of Area Mental Health Programs, were enacted by Chapter 470 of the 1971 North Carolina Session Laws. (Article 2C of G.S. Chapter 122 is contained in Appendix II.) Under G.S. 122-35.19(1), the North Carolina Board of Mental Health is given authority to establish area mental health

programs "to consist of a combining and interrelationship of resources, personnel, and facilities of the Department of Mental Health, and of the community mental health program to serve the population of the area designated pursuant to this Article." Other sections of Article 2C provide for Area Mental Health Boards, with equitable area-wide representation consisting of county commissioners, physicians, attorneys and other citizens at large.

In 1965 the North Carolina Department of Mental Health had already been reorganized under four mental health regions, each with its own commissioner. Each region contains a mental hospital, a mental retardation center, and an alcoholism program. The 1971 legislation made possible further decentralization. The decentralization under the area program has had the effect of shifting authority for mental health programs from elected county commissioners to area policy boards appointed by them. To date, the area concept has not been fully implemented, nor has its ultimate function been fully developed or clarified.

The Committee quickly concluded that the sponsor of HJR 715 had no real quarrel with the Area Programs per se but that they were largely concerned with another program called the "Geographic Unit" concept.

THE GEOGRAPHIC UNIT

In 1848 North Carolina began a program of institutional care for the mentally ill. Hospitals competed for funds under this program until the creation of the Hospital Board of Control in 1945. The Department of Mental Health was established as a state agency in 1964 and a few years later took over some local mental hygiene clinics from the Department of Public Health. At this point, North Carolina was providing very limited out-patient care to a few people. At the same time, the State was providing some acute care and a large amount of custodial care at centralized institutions. There was little linkage between community programs and institutions, and there was no comprehensive system for the delivery of mental health services.

Three hospitals were serving white patients and one institution was serving black patients. In 1965 all four hospitals were racially integrated, and the state was divided into four regions -- each with a mental hospital for adult patients. This change generated much anxiety for hospital staffs within the system as well as for families of the patients involved -- especially at Cherry, the formerly all black institution.

Shortly following integration, the geographic unit system was introduced. It had been widely applauded in professional psychiatric and administrative journals throughout the United States. Its application involves the decentralization of large institutions (North Carolina's four) into what amounts to several small hospitals, called units, each with its own provision for continuity of care. Patients are grouped according

to the community or geographic catchment area in which they reside. Men and women patients are mixed, and no attempt is made to segregate them by symptoms of illness. Admission is directly to the unit rather than to a central admissions service.

It was hoped that the unit system would achieve these goals:

1. Provide comprehensive and continuous care for psychiatric patients by improving hospital community linkage.
2. Decentralize large state hospitals to provide management decisions close to the local situation.
3. Minimize the concept of "chronic" patients and to provide active treatment for all patients.

Though lofty in concept, in practice and in application the geographic unit program has created strain on the mental health system bordering on turmoil. It has also caused staffing duplication.

Back ward patients (long term, chronic, regressed) have been thrust together with admission ward patients (less seriously disturbed). This does help the back ward patient, but in some cases has severely disturbed the admission ward patient (and his family!). If they are split into several programs the quality of certain specialized services, such as an adolescents' program or an alcoholism program, inevitably suffers; the necessary specialized skills have simply been spread too thin.

CONCLUSIONS AND RECOMMENDATIONS

Perhaps as a result of HJR 715 itself, the state regional hospitals are retreating markedly from the geographic unit

emphasis. For example, more than fifty percent of the Dorothea Dix population is now back in special units /Admission, Geriatric (elderly), Nursing Care, Infirmary, Forensic (criminal), Medical Surgical, Research, Resocialization and Alcoholic/ rather than geographic units. The Department is now exploring revising the geographic unit system in two areas (Southeastern and Sandhills) and going entirely to special programs.

Thus we find that the tension and frustration which gave rise to House Joint Resolution 715 is already beginning to subside. The investigation by your committee has already served a great purpose. Our hope is that the analysis of this report might hasten the modification of the geographic unit program now under way within the system at large.

In carrying out this modification the Committee feels that the following specific recommendations will be useful:

1. Newly admitted elderly patients should be treated in a single geriatric admission and evaluation unit no matter what community they come from.
2. Moderately disturbed or depressed patients should not be evaluated or treated in the same ward area as are the more chronic or seriously disturbed patients.
3. As patient census decreases, more specialized programs should remain intact.

Appendix I

Resolution Directing the Study.

GENERAL ASSEMBLY OF NORTH CAROLINA
1971 SESSION
RATIFIED BILL

RESOLUTION 66

HOUSE JOINT RESOLUTION 715

A JOINT RESOLUTION AUTHORIZING AND DIRECTING THE LEGISLATIVE RESEARCH COMMISSION TO STUDY THE AREA UNIT CONCEPT OF TREATMENT OF THE MENTALLY ILL IN THE STATE MENTAL HOSPITALS.

Whereas, the North Carolina Department of Mental Health has implemented a "geographical unit" concept for treatment of the mentally ill; and

Whereas, the State's four mental hospital facilities have been divided into units serving patients only from a specific county or counties; and

Whereas, each such unit may require fixed staffing and supporting services despite the variation in the number of patients cared for within each unit; and

Whereas, there exists under such operations the possibility of unequal distribution of patients and staff among units;

Now, therefore, be it resolved by the House of Representatives, the Senate concurring:

Section 1. The Legislative Research Commission with advice, direction and assistance of the Advisory Budget Commission is hereby authorized and directed to study the "geographical unit" concept within the state mental hospitals to evaluate the practicality, the effectiveness and the economy of this type of operation.

Sec. 2. The Legislative Research Commission shall report its findings and recommendations to the 1973 General Assembly.

Sec. 3. This resolution shall become effective upon ratification.

In the General Assembly read three times and ratified, this the 14th day of May, 1971.

H. P. TAYLOR, JR.

H. P. Taylor, Jr.
President of the Senate

PHILIP P. GODWIN

Philip P. Godwin
Speaker of the House of Representatives

Appendix II

Article 2C.

Establishment of Area Mental Health Programs.

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§ 122-35.18. Definitions.—For purposes of this Article, the following definitions shall apply:

(1) "Area" means a geographic entity consisting of one or more counties, or portions of one or more counties, designated by the Board of Mental Health as a basic unit for the development of mental health programs to serve the population of that geographic entity.

(2) "Mental health program" means any services or activities, or combination thereof, for the diagnosis, treatment, care, or rehabilitation of mentally impaired persons or for the promotion of mental health, which is offered by or on behalf of the geographic entity established pursuant to this Article. (1971, c. 470, s. 1.)

Editor's Note.—Section 2, c. 470, Session Laws 1971, makes the Article effective July 1, 1971.

§ 122-35.19. Area mental health programs.—The North Carolina Board of Mental Health is authorized to establish area mental health programs. These shall be joint undertakings of the counties or portions thereof, included in the designated area, and the Department of Mental Health for the following purposes:

(1) To develop area mental health programs, to consist of a combining and interrelationship of resources, personnel, and facilities of the Department of Mental Health, and of the community mental health program to serve the population of the area designated pursuant to this Article. The area mental health program shall include, but not be limited to, programs for general mental health, mental disorder, mental retardation, alcoholism, drug dependence, and mental health education.

(2) With the approval of the Department of Administration, to develop and test budgeting procedures for combining local and State grants-in-aid funds with a proportional share of funds appropriated for the operation of departmental facilities serving the population of the area. Provided that "local funds" and "State grants-in-aid" shall be defined and determined in accordance with the provisions of G.S. 122-35.11 and G.S. 122-35.12, and shall be unaffected by the addition of funds appropriated for the operation of State facilities.

(3) To evaluate the effectiveness and efficiency of area mental health programs. (1971, c. 470, s. 1.)

§ 122-35.20. **Area mental health boards.** — (a) In areas where area mental health programs are established in accordance with this Article, an area mental health board shall be appointed for each designated area. The area mental health board shall consist of 15 members and shall meet at least six times per year.

(b) In areas consisting of only one county, the board of county commissioners shall appoint all of the members of the area mental health board. In areas consisting of more than one county, each board of county commissioners within the area shall appoint one commissioner as a member of the area mental health board. These members shall appoint the other members of the area mental health board in such a manner as to provide equitable area-wide representation.

(c) The area mental health board shall include:

(1) At least one commissioner from each county;
(2) At least two persons duly licensed to practice medicine in North Carolina;
(3) At least one representative from the professional fields of psychology, or social work, or nursing, or religion;
(4) At least three representatives from local citizen organizations active in mental health, or in mental retardation, or in alcoholism, or in drug dependence;
(5) At least one representative from local hospitals or area planning organizations;
(6) At least one attorney practicing in North Carolina.

(d) Any member of an area mental health board who is a public official shall be deemed to be serving on the board in an ex officio capacity to his public office. The ex officio members shall serve to the end of their respective terms as public officials. The other members shall serve four-year terms, except that upon initial formation of an area mental health board, three members shall be appointed for one year, two members for two years, three members for three years, and all remaining members for four years.

(e) Subject to the supervision, direction, and control of the State Board of Mental Health, the area mental health board shall be responsible for reviewing and evaluating the area needs and programs in mental health, mental impairment, mental retardation, alcoholism, drug dependence, and related fields, and for developing jointly with the State Department of Mental Health an annual plan for the effective development, use and control of State and local facilities and resources in a comprehensive program of mental health services for the residents of the area. (1971, c. 470, s. 1.)

§ 122-35.21. **Appointment of area mental health director.**—The area mental health board of each area established pursuant to this Article shall appoint, with the approval of the Commissioner of Mental Health and the State Board of Mental Health, an area mental health director. The area mental health director shall be the employee of the area mental health program, responsible to the area mental health board for carrying out the policies and programs of the area mental health board, and of the State Board of Mental Health. (1971, c. 470, s. 1.)

§ 122-35.22. **Clinical services.**—All clinical services under an area mental health program shall be under the supervision of a person duly licensed to practice medicine in North Carolina. (1971, c. 470, s. 1.)